HFS Prior Approval Form for
Synagis (pavilizumab)
2005-2006 Season

SYNAGIS PRIOR APPROVAL REQUEST FORM

A. PHYSICIAN INFORMATION **ALL Information Requested On This Form Must Be Complete**

Physician Name: _____ DEA #: _____ License #: _____

	YES	NO
Prescriber is a Pediatrician?		

(If NO, list specialty) _____ Office phone #: _____

B. PHARMACY INFORMATION

Pharmacy Name: _____ Pharmacy I.D. #: _____ Pharmacy Phone #: _____

C. PATIENT INFORMATION

Patient Name:_____ DOB_____/_____/_____ **Patient 9 digit IDPA Recipient Number:**_____

Gestational Age at Birth: _____ **Diagnosis**: _____ ☐ first season ☐ second season ☐ other _____

Birth Weight: _____ Current **Unclothed** Weight (and date)*: _____ **Dose:** 15mg/kg = _____ **Nearest vial size: 50mg / 100mg**

D. PATIENT INFORMATION

- ☐ **Infant born at 28 weeks gestation or earlier with birth date after October 1, 2004**
- ☐ **Infant born at 29 - 32 weeks gestation or earlier with birth date after April 1, 2005**
- ☐ **Child born after October 1, 2003 with hemodynamically significant congenital heart disease**
- ☐ **Child born after October 1, 2003 with chronic lung disease requiring treatment within the last 6 months (define treatment in section E)**
- ☐ **Child born after October 1, 2001 requiring mechanical ventilation for lung disease**
- ☐ **Child born between 32 and 35 weeks gestation and is currently under 6 months of age with the following risk factors: (list below)**

E. NOTES:

Important: To prevent delay, fax relevant patient information along with this form or provide such information below. If weight changes during the season, please indicate new weight and date below.

F. PHYSICIAN or DESIGNEE'S SIGNATURE: **Date:**

COMPLETE ALL INFORMATION TO INSURE PROMPT PROCESSING

CREATED 7/28/2005

FAX TO : 217-524-7264
ATTN: MEDICAL COMMITTEE